

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2010
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NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 000</p> <p>F 272 SS=D</p>	<p>INITIAL COMMENTS</p> <p>An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection from February 16, 2010 to February 18, 2010. The following regulatory deficiencies were found.</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p>	<p>F 000</p> <p>F 272</p>	<p>Allegation of Substantial Compliance</p> <p>Vernon Green Nursing Home, has and continues to be in substantial compliance with 42 CFR Part 483 subpart B. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein.</p> <p>This Plan of Correction constitutes Vernon Green Nursing Home's allegation of substantial compliance.</p> <p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.</p> <p>F272 Comprehensive Assessments</p> <p>The facility has and continues to ensure residents have a comprehensive resident assessment.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident had been reweighed on 02/02/10. Policy and Procedure for resident Weights has been revised. <i>POC complete 3/16/10</i> <i>G Culm SHJA</i></p>	<p>02/18/10</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. Bradford Ellis</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>March 23, 2010</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 02/22/10

All residents have the potential to be affected.

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; 03/26/10

All residents will be weighed weekly or as recommended/ordered by MD/dietician. If a discrepancy is noticed the resident will be re-weighed within twenty-four hours.

On or before March 26, 2010, licensed nursing staff will attend an in-service. The in-service will be conducted by the Director of Nursing or designee. The in-service will cover

- Review of the regulation
- Review of the statement of deficiency
- Review of the plan of correction
- Care plan development
- Goals including measurable goals-dates
- Revision and updating of care plans as needed
- Importance of weights and re-weights if there is a discrepancy

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? 03/22/10

Beginning 03/11/2010 the Director of Nursing (DON) or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance. The audits will be conducted weekly for a month, the monthly for one quarter and/or until 100% compliance is achieved. The DON or designee will report the results of the audits to the Quality Assurance committee who will determine the further monitoring.



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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to reassess one applicable resident with weight loss in the total stage 2 sample of 22. (Resident # 58) Findings include: Per record review conducted on 2/18/10 at 9 a.m., Resident # 58's weight was documented on a weight list sheet in the resident's chart as being 166.4 lbs. Per review of the 3-month weight sheet (Jan/Feb/March 10) located in a separate binder at the nursing station showed a weight of 150.2 lbs. on 1/26/10 which indicated a 16.2 weight loss from the prior week. In addition, a review of the resident's meal intake percentages showed that there were 17 meals that he/she had eaten 50% or less of their meals and 5 times that they had refused their meal outright. The charge nurse confirmed during interview on 2/18/10 at 9:15 AM that she had failed to complete a timely assessment of the resident's weight loss. Per interview on 2/18/10 at 9:15 a.m. the charge nurse confirmed that facility staff failed to re-weigh and to re-assess the resident's weight loss after obtaining the weight of 150.2 lbs. on 1/26/10.	F 272			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279	F279 Comprehensive Care Plans The facility has and continues to ensure that the facility revises and/or reviews care plans as needed. How will corrective action be accomplished for those residents found to have been affected by the deficient practice; Resident #67 and resident # 74 care plans have been reviewed to ensure the care plans continue to accurately reflect the resident's status and have measureable goals and timely goal dates.	2/18/10	

F272 continued from page 3

On or before March 26, 2010, nursing staff will attend an in-service. The in-service will be conducted by the Director of Nursing or designee. The in-service will cover

- Review of regulation
- Review of the statement of deficiency
- Review of the plan of correction
- Care plan development
- Goals including measurable goals-dates
- Revision and updating of care plans as needed

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

03/22/10

Beginning 03/11/2010 the Director of Nursing (DON) or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance. The audits will be conducted weekly for a month, then monthly for one quarter and/or until 100% compliance is achieved. The DON or designee will report the results of the audits to the Quality Assurance committee who will determine the need for further monitoring.



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F 279	Continued From page 3 aspect of the resident's care. This was confirmed during interview with both unit manager and MDS coordinator at 4:35 PM on 02/17/2010. Both staff confirmed that this should be on the resident's care plan	F 279		
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that care plans for 4 of 22 residents in the stage 2 sample were revised to reflect each resident's current assessed needs. (Residents #22, 19, 17 & 58) Findings include:</p> <p>1. Per record review and confirmed during</p>	F 280	<p>F280 Comprehensive Care Plan</p> <p>The facility has and continues to ensure that the facility revises and/or reviews care plans as needed.</p> <p>How will corrective action be accomplished for those residents found to have been affected by the deficient practice;</p> <ol style="list-style-type: none"> 1. The care plan for resident # 22 has been reviewed to ensure the plan of care continues to accurately reflect the resident's current status and has measurable goals. 2. The care plan for resident # 19 has been reviewed to ensure the care plan continue to accurately reflect the resident's status. 3. The care plan for resident # 17 has been reviewed to ensure the plan of care reflects current and accurate information and has measurable goals. 4. The care plan for resident # 58 has been reviewed to ensure the plan of care continues to accurately reflect the resident's current status and has measurable goals. 	02/19/10

Pre audit 3/16/10
G. Chinn

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F 280	Continued From page 4 interviews with the MDS nurse and the staff nurse on the afternoon of 2/17/10, Resident #22's care plan was not revised to include the development of bowel incontinence, behaviors including resistance to personal care, and a history of frequent bruising and skin tears due to fragile skin. 2. Per record review and confirmed during interviews with the MDS nurse and the Licensed Nursing Assistant (LNA) providing care on the afternoon of 2/17/10, Resident #19's care plan did not include the provision of Range of Motion (ROM) exercises to the lower extremities with daily care. 3. Per record review and confirmed during interview with the staff nurse on the morning of 2/18/10, Resident #17's care plan did not include the specific type of medical access device in use and failed to identify the frequency of monitoring to the site. This was also confirmed with the MDS nurse the same day. 4. Per record review for Resident #58 on 2/18/10 at 9 AM, staff failed to update the comprehensive care plan to include a significant weight loss. Resident # 58 experienced a weight loss of 16.2 lbs between the dates 1/19/10 and 2/2/10. Per interview with the charge nurse on 2/18/10 at 9:15 AM, he/she confirmed that the care plan had not been updated to reflect the resident's weight loss.	F 280	<u>F280 continued</u> How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 1. The care plans for all residents that have developed bowel incontinence, behaviors including resistance to personal care and a history of frequent bruising and skin tears due to fragile skin will be reviewed to ensure the plan of care continues to accurately reflect the resident's status. 2. The care plans for all residents that receive Range of Motion (ROM) exercise will be reviewed to ensure that their plan of care continues to accurately reflect the resident's status. 3. The care plans for all residents that have specific medical access devices in use will be reviewed to ensure that their plan of care continues to accurately reflect the resident's status. 4. The care plans for all residents that have had a significant weight loss will be reviewed to ensure that their plan of care continues to accurately reflect the resident's status and has measureable goals. <i>pol corrected 3/16/10 C. Coleman</i>	03/26/10	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323			

F280 continued from page 5

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur;

03/26/10

On admission, significant change in resident status and as residents come due for their next MDS (Minimum Data Set) assessment, resident's care plans will be reviewed to ensure the care plans continue to accurately reflect the resident's status and have measurable goals and timely goal dates.

On or before March 26, 2010, licensed nursing staff will attend an in-service. The in-service will be conducted by the Director of Nursing or designee. The in-service will cover

- Review of the regulation
- Review of the statement of deficiency
- Review of the plan of correction
- Care plan development
- Goals including measurable goals-dates
- Revision and updating of care plans as needed

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

03/22/10

Beginning 03/11/2010 the Director of Nursing (DON) or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance. The audits will be conducted weekly for a month, then monthly for one quarter and/or until 100% compliance is achieved. The DON or designee will report the results of the audits to the Quality Assurance committee who will determine the need for further monitoring.

*Per report 3/16/10
G. [Signature]*

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F 323	<p>Continued From page 5</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to assure that the resident environment was as free of accident hazards as possible.</p> <p>Findings include:</p> <p>1. Per observation on 2/16/10 at 12:08 PM, Resident # 67 was seen exiting the building through an alarmed door at the end of a hallway on the Special Care Unit (SCU) without triggering the door alarm. No SCU staff witnessed the resident exit the building. Wearing only indoor clothing, Resident #67 proceeded to walk along the building on an exterior walkway during a snowstorm and re-entered the building through a door leading to the SCU resident dining area. The exterior walkway 's outer perimeter was enclosed by permanent metal fencing. The non-functioning door alarm status was immediately confirmed by the facility Administrator and the security alarm system company was notified. Per record review, the SCU staff had documented door alarm testing on every shift, including on the morning of 2/16/10.</p> <p>2. Per observation during the three days of survey, an orange plastic temporary fencing material was being used as a barricade to prevent resident access from the SCU exterior walkway to an outdoor fenced-in garden area. An</p>	F 323	<p><u>F 323 Accidents</u></p> <p>The facility has and continues to ensure that the residents environment is free of accidents, hazards and provides adequate supervision and assistance devices to prevent accidents.</p> <p>The facility requests an informal dispute resolution for Tag F 323; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 323; respectfully denies and disputes the allegation that it was deficient in respect to F 323; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 323 caused any harm or potential for any harm to any facility residents; and requests that F 323 be deleted from the public record.</p> <p>The facility will show:</p> <p>(A) The facility was in substantial compliance with F 323 by ensuring that the resident environment was as free from accidents and hazards as possible; that each resident received adequate supervision to prevent accidents and that adequate devices were installed to prevent accidents;</p> <p>(B) The facility monitors all of its alarm functionality either daily or during each shift to insure accident prevention;</p> <p>(C) That although the facility experienced an alarm failure, it followed its procedures to insure resident safety;</p>		

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F 323	<p>Continued From page 6</p> <p>approximately 30 inch slit in the plastic barricade and an open area at a bottom corner of the barricade was noted. The exterior walkway is accessible to all ambulatory SCU residents. Per interview on the afternoon of 2/16/10 and on the morning of 2/18/10, the Director of Nursing Services (DNS) stated that Resident # 67 had made several previous attempts to go through the temporary plastic barricade requiring the intervention of SCU staff.</p> <p>3. Per observation on 2/17/10 at 3:06 PM during a tour of the facility with the Hospitality Director, a door accessible to all ambulatory residents on A Wing was noted to be alarmed only for residents wearing security alarm bracelets. The door opened into a corridor leading to several unsecured storage rooms and egress to the outside. The rooms included an operational laundry chute, a room with unsecured carpentry and maintenance tools, a room with cleaning and paint products, and a storage room with personal hygiene products. In addition, this wing led to the facility 's loading dock and had access to the power operated overhead doors. There was unsecured access to a trash compactor with an approximate 12 foot drop from the unsecured manual overhead door. An unsecured exit door leading to a steep exterior staircase was also accessible via this corridor. Per interview on the afternoon of 2-17-10, the Administrator confirmed that the door should be secure alarmed for all residents and immediately had the maintenance department change the secure alarm that would protect all residents from the potential hazard.</p> <p>4. Per observation on 2/17/10 at approximately 4 PM during a tour of the SCU with the Hospitality Director, the SCU exterior door alarm was not</p>	F 323	<p><u>F323 continued</u></p> <p>(D) The facility has a functioning redundant alarm system on the Special Needs Unit patio/garden area that was functioning during the alarm failure to further protect residents and prevent accidents;</p> <p>(E) No residents have been identified has having been harmed or potentially harmed by any alleged deficient practice, and there is no evidence the facility failed to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident;</p> <p>(F) The finding contradicts the substantial compliance findings of at least four previous surveys</p> <p>Note: in the following paragraphs, the numerals refer to the Summary Statement of Deficiencies sections for F 323.</p> <p><u>F323 Finding 1.</u> The surveyors' observation of resident #67 exiting the Special Needs Unit's (SNU) hallway door to enter the patio/garden area without triggering the door alarm is true. This was the first instance of the door alarm not working. As the surveyor indicated, the alarm was tested at the beginning of the shift and had been working until this incident at 12:08pm on 2/16/2010. The facility does not deny the alarm failure. However, the facility submits that it acted prudently and quickly in following our procedures for this contingency. Indeed, these contingency procedures exist because the facility is realistic in its inability to</p>		

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guarantee the prevention of any failures to our myriad mechanical systems.

Upon realizing the alarm system failed, the facility immediately established a door watch protocol utilizing a single staff member dedicated to only watching both garden/patio doors for residents entering and exiting into the garden/patio area. This door watch continued, uninterrupted until 3:30pm on 2/18/10. In addition, although the patio/garden area door alarms were not functioning, the outside gate alarm was working (it is a redundant alarm on a different system). At no time during the alarm outage could a resident leave the Special Needs Unit unnoticed. The facility complied with the surveyors' request that a resident head count be taken every 30 minutes but at no time were there any residents whose locations were not immediately known.

The alarm technician arrived promptly after being notified and determined that this alarm system had sustained a power surge that caused its programming to revert to default factory settings. He reprogrammed the alarm system and altered the reset procedure. The Hospitality Services Director (HSD) misunderstood the changes when he created a new instruction sheet. Due to this error, the alarm reacted differently after this repair than was expected and the staff was hearing two different tones. The alarm technician was consulted by phone two more times before coming in on 2/17/10 to further diagnose the issue. This was when the reset procedure was found to differ from the new instructions.

The original alarm tone was a repeated beeping to indicate a patio/garden door was open. The staff would have to manually reset the alarm to shut off the beeping after checking on the reason for the door being opened. This original programming included a silent 20 second period during the reset when a door could have been opened and no audible alarm would sound (there would have been two visible indicators on the keypad). The technician reprogrammed the alarm on 2/16/10 so there was an audible alarm (a long single tone) during this reset period if the door was opened. This was not understood by the HSD and so was miscommunicated to the staff. On 2/18/10 the instructions were changed to reflect this added safety feature. It is important to note that from the initial repair on 2/16/10 to the follow-up visit on 2/17/10, the door watch protocol was never broken and the locations of all residents—including those in the patio/garden area—were always known.

On 2/16/10, due to the power surge issue, the facility consulted with its Master Electrician and the alarm technician about the best way to prevent this from happening again. On 2/16/10 the facility installed a

F323 continued from page 7a

battery back-up surge protector in the power circuit for the alarm.

The SNU is specifically designed to care for residents with dementia and was the first such unit in Vermont. We have cared for residents on the SNU for twenty-one years. The garden/patio area is an integral component of our program and it allows wandering residents a circuitous, unrestricted route of travel. It is the facility's experience that residents who need to be able to walk and explore are less prone to behavioral issues and enjoy a higher quality of life than a resident restricted to a one-way hall or corridor.

The garden/patio is open twenty-four hours per day, every day of the year. In the winter, we prevent residents from entering the open garden areas due to snow and ice concerns; however the remaining area is completely covered. This area offers residents a walking path approximately 100 feet in length that is snow and ice free. It is open to the fresh air and surrounded by an attractive fence. Resident #67, who uses this pathway frequently, is often quite resistant when staff attempt to intervene for her comfort.

The surveyors state that resident #67 went outside in a snowstorm with "only indoor clothing". This resident's medical record is replete with instances of unalterable behaviors and will frequently remove sweaters and other clothing articles.

F323 Finding 2. The facility has used the orange plastic fencing successfully on Special Needs Unit (SNU) and even on the Rose Room patio for several years, including during the previous survey in January 2009. The facility's experience during this time is that most residents, including those with dementia, recognize the orange color as a hazard to be avoided. The orange fencing on the SNU was replaced on 2/18/10 with white lattice-work paneling.

The facility considers both fencing types fall prevention apparatuses (versus elopement deterrents) that are used to prevent residents from walking on snow and ice in the open garden area. This part of the garden has no roof and contains the raised flower and vegetable beds used by residents during the spring and summer. Surrounding this part of the garden is the same type of attractive fencing surrounding the SNU walk-way.

In addition, the 30" slit in the plastic fencing was not immediately visible and the origin, date and time of the slit's creation is indeterminate. Moreover, the opening at the bottom corner as noted by the surveyors was so small as to not warrant a repair.

F323 continued from page 7b

The surveyor's statements about the attempts of resident #67 to penetrate the barrier and requiring staff intervention to prevent resident #67 from walking on the snow and ice are true. The facility respectfully submits however that the orange fencing, coupled with the door alarms leading to the patio/garden area walk-way, worked to warn staff that resident #67 had entered this area and provided staff ample time to redirect resident #67 before she could encounter the snow and ice. Following these attempts by resident #67 to penetrate the orange fencing, the facility added a second course of fencing to increase its height. This proved a successful solution to assisting resident # 67 in ambulating independently and safely in the SNU walk-way.

F323 Finding 3. The facility installed a combination alarm and magnetic lock on the door leading to the loading dock around September 2005. The programming for this alarm and lock did not change until 2/17/10. It was originally configured to prevent residents who wore a Wanderguard bracelet from entering this door by alerting staff with an audible alarm if an attempt was made. If a resident approached the alarm wearing a Wanderguard bracelet, the magnetic lock and audible alarm would activate when the resident approached within five feet of the door. The reprogramming requires a code to be entered before any entry.

In the four plus years since installation, the facility did not have a resident enter this area. The only exception was when a resident who smoked was escorted to the smoking room down this corridor under immediate and close staff supervision during the entire time (this smoking room was converted to storage in January 2009).

The facility questions the use of the word unsecured when describing this area and is confused about the surveyors' finding that this area is out of compliance. The area was (and continues to be) secured by the alarm and magnetic lock. This alarm and lock system retained its original programming from installation until 2/17/10 and had been found in substantial compliance during the 2006, 2007, 2008 and 2009 surveys. The facility has always evaluated all new admissions for unsafe wandering and the need for safety interventions. Indeed, the facility utilizes the same alarm and magnetic alarm system to secure two other doors. These doors lead to the main entrance walk-way, a sidewalk, driveway and parking lots. The original programming is still used in these and both were determined to be in substantial compliance during this survey and all previous ones since their installation. One of these doors is within sight of the locking dock door and the other can be sighted within thirty feet.

F323 continued from page 7c

The Wanderguard bracelet system has proven itself a reliable, convenient system that adds to the dignity and quality of life for residents while keeping them safe. With the use of the Wanderguard system it was the facility's understanding until this survey that it was in compliance with the regulatory language "ensuring that the resident environment be as free from accidents and hazards as possible". The following are some additional explanations that need to be considered as to the validity of finding the alarm programming out of compliance and an environmental hazard to residents;

- i. The loading dock area is for staff use only.
- ii. This area has a high level of staff traffic
- iii. The personal hygiene products are the same type of products that would be kept in a resident's bedside cabinet for personal care.
- iv. The laundry chute has a latching mechanism on the access panel door per life safety code.
- v. Access to the trash compactor can only be gained by manually opening a five foot wide garage door and then climbing over a 34.5" guardrail. This guardrail was approved by Vermont's Occupational Safety and Health Administration (VOSHA)
- vi. The exit door cannot be secured per fire code because it is the designated egress for the loading dock area (this is not an egress route from the alarmed and locked loading dock door). Moreover, the stairs leading from it to the parking lot have been inspected and approved by VOSHA and the Vermont Department of Public Safety. Their tread size of 11 ¼" and tread rise of 6 ¾" is well within published and recognized standards of safe stair design. The facility thus respectfully disagrees with the term steep as described in the finding by the surveyors.
- vii. The facility's administrator respectfully asserts that he is misquoted in this finding. He acknowledged the surveyors' concerns but did not confirm them. In addition, he had the alarm reprogrammed to alleviate the surveyor's concerns which he hoped could be assuaged in further discussions.

Lastly, the facility has and will continue to monitor, test and document the functionality of all the building alarms and the Wanderguard bracelets daily to insure resident safety.

F323 Finding 4. The alarm technician was called back in to reprogram the alarm system and altered the reset procedure on 2/17/10. The Hospitality Services Director (HSD) misunderstood the changes when he, the HSD,

F323 continued from page 7d

created a new instruction sheet for staff. Due to this error, the alarm reacted differently after this repair than was expected and the staff was hearing two different tones. The alarm technician was consulted by phone two more times before coming in on 2/17/10 to further diagnose the issue. This was when the reset procedure was found to differ from the new instructions.

The original alarm tone was a repeated beeping to indicate a patio/garden door was open. The staff would have to manually reset the alarm to shut off the beeping after checking on the reason for the door being opened. This original programming included a silent 20 second period during the reset when a door could have been opened and no audible alarm would sound (there would have been two visible indicators on the keypad). The technician reprogrammed the alarm on 2/16/10 so there was an audible alarm (a long single tone) during this reset period if the door was opened. This was not understood by the HSD and so was miscommunicated to the staff. On 2/18/10 the instructions were changed to reflect this added safety feature. It is important to note that from the initial repair on 2/16/10 to the follow-up visit on 2/17/10, the door watch protocol was never broken and the locations of all residents—including those in the patio/garden area—were always known.

Even though this door alarm was not functioning consistently (due to resetting errors) the residents were being kept safe and observed with a single staff member dedicated to only watching both garden/patio doors for residents entering and exiting.

The facility did respond appropriately to the situation to insure resident safety.

The facility has demonstrated and proved:

- (A) The facility was in substantial compliance with F 323 by ensuring that the resident environment was as free from accidents and hazards as possible; that each resident received adequate supervision to prevent accidents and that adequate devices were installed to prevent accidents;
- (B) The facility monitors all of its alarm functionality either daily or during each shift to insure accident prevention;
- (C) That although the facility experienced an alarm failure, it followed its procedures to insure resident safety;
- (D) The facility has a functioning redundant alarm system on the Special Needs Unit patio/garden area that was functioning during the alarm

F323 continued from page 7e

failure to further protect residents and prevent accidents;

- (E) No residents have been identified as having been harmed or potentially harmed by any alleged deficient practice, and there is no evidence the facility failed to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident;
- (F) The finding contradicts the substantial compliance findings of at least four previous surveys.

The facility requests an informal dispute resolution for Tag F 323; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 323; respectfully denies and disputes the allegation that it was deficient in respect to F 323; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 323 caused any harm or potential for any harm to any facility residents; and requests that F 323 be deleted from the public record.

The facility respectfully requests that this finding, F 323, be removed from the record.

How will corrective action be accomplished for those residents found to have been affected by the deficient practice;

02/18/10

1. When the hallway door alarm was discovered to be non-functioning on 2/16/10, a staff member was immediately positioned at a point in the hallway, opposite the nursing station, so that both of the doors leading to the exterior walk-way could be observed. This staff member had no other duties when performing the door watch. In addition, staff completed head counts of residents every 30 minutes to insure all residents were present. (The door watch and head counts ceased after 3:30 p.m. on 2/18/10 when the door alarm had functioned appropriately for 24 hours.) The alarm technician determined on 2/16/10 that the alarm control panel had received a power surge which caused the programming to default to the factory settings. The alarm control panel was reprogrammed by the technician, tested and found to be working. On 2/16/10 a surge protector was installed on the alarm system's power supply circuit to prevent alarm failure from power surges.
2. The plastic fencing was removed and replaced on 2/18/10 with lattice-work panels.
3. The door alarm was reprogrammed on the afternoon of 2/17/10 to prevent any entrance into this area without entering the proper code.

*Ref
Am
2/18/10
JL*

4. This door alarm (the same one from #1 above) was serviced on 2/17/10 by the same alarm technician who had serviced it on 2/16/10. The alarm technician determined that the alarm was functioning properly but the reset procedure was not being followed properly. This procedure had been changed on 2/16/10 but communicated incorrectly by the Director of Hospitality Services to the Special Needs Unit staff. Once the new reset instructions were employed, the alarm functioned as expected.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

02/18/10

1. All ambulatory residents on the Special Needs Unit are affected by the functionality of the unit's door alarms. Thus procedures for staff door watches during alarm failures were in place and used correctly during this incident. This will continue to be employed in the future as needed.
2. All ambulatory residents on the Special Needs Unit are affected by any fall prevention apparatus that are employed in the patio/garden areas.
3. Residents determined to need observation for safety during locomotion and who are not wearing a Wanderguard bracelet have the potential to be affected by the previous settings on this alarm.
4. All ambulatory residents on the Special Needs Unit are affected by the functionality of the unit's door alarms. Thus procedures for staff door watches during alarm failures and servicing were in place and used correctly during this incident. This will continue to be employed in the future as needed.

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur;

02/18/10

1. Vernon Home will continue to monitor the functionality of this alarm system during each shift. Although the facility cannot guarantee this alarm system, like any other mechanical device, will never fail, it will institute its contingency procedures from the time the alarm system is found to be non-functional until its repair. The surge protector will continue to be a dedicated part of the alarm system's power source.
2. The facility will continue to provide fall prevention apparatus in the garden/patio area as needed.

3. The facility will continue to keep the revised alarm settings on this door that prevent entry unless the correct code is entered.

4. Vernon Home will continue to monitor the functionality of this alarm system during each shift. Although the facility cannot guarantee this alarm system, like any other mechanical device, will never fail, it will institute its contingency procedures from the time the alarm system is found to be non-functional until its repair. The surge protector will continue to be a dedicated part of the alarm system's power source.

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

03/22/10

1. The alarm system checks, for the Special Needs Unit (SNU) patio/garden area doors, will continue to be performed by the charge nurse on each shift. The alarm checks will continue to be documented on the Alarm Check Log located at the SNU nurses' station. The documentation will be reviewed weekly by the Quality Nurse or designee for staff compliance. Completed log sheets will be kept on file for one year.

2. The integrity of the fall prevention apparatus in the Special Needs Unit (SNU) patio/garden area will be monitored daily and recorded on the Alarm Check Log by any SNU staff. The correct procedures to follow if the fall prevention apparatus integrity is breached will be attached to the Alarm Check Log clipboard or binder. The documentation will be reviewed weekly by the Quality Nurse or designee for compliance. Completed log sheets will be kept on file for one year.

3. The loading dock alarm will be checked daily by any nursing or maintenance staff for functionality and programming adherence to block all traffic unless the correct code is entered. These alarm checks will be documented in the Daily Wanderguard log and reviewed weekly by the Quality Nurse or designee for compliance. These logs will be kept on file for one year.

4. The alarm system checks, for the Special Needs Unit (SNU) patio/garden area doors, will continue to be performed by the charge nurse on each shift. The alarm checks will continue to be documented on the Alarm Check Log located at the SNU nurses' station. The documentation will be reviewed weekly by the Quality Nurse or designee for staff compliance. Completed log sheets will be kept on file for one year.

The Quality Nurse will report to the Quality Assurance committee on compliance.

Beaman
3/30/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2010
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NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323	Continued From page 7 consistently functioning and the security alarm company was re-notified. Per interview at the time of the tour, the Hospitality Director confirmed the alarm system was not fully functioning and took steps to resolve the issue.	F 323		
F 325 SS=G	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 applicable resident in the stage 2 sample who experienced a significant weight loss maintained acceptable parameters of nutritional status. (Resident #58) Findings include:</p> <p>1. Per record review on 2/18/10 at 9 AM, Resident #58, who had multiple comorbidities, sustained a 16.2 lb. weight loss between the dates of 1/19/10 when his/her weight was documented at 166.4 lbs and 1/26/10 when his/her weight was documented as 150.2 lbs. Per observation of 2 meals on 2/16/10 and 2/17/10, the resident was able to eat his meals independently. A review of the resident's meal intake percentages between</p>	F 325	<p>F325 Nutrition</p> <p>The facility has and continues to ensure that the residents maintain acceptable parameters of nutritional status and receive a therapeutic diet when there is a nutritional problem.</p> <p>The facility requests informal dispute resolution for Tag F 325; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 325; respectfully denies and disputes the allegation that it was deficient in respect to F 325; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 325 caused any harm or potential for any harm to any facility residents; and requests that F 325 be deleted from the public record.</p> <p>The facility will show:</p> <p>(A) The facility was in substantial compliance with F 325 as the resident's clinical condition prohibited him from maintaining acceptable parameters of nutritional status;</p> <p>(B) The finding contradicts the regulation that states "maintains acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that this is not possible;</p>	

F323 continued from page 8

(C) There was no actual harm caused to the resident

(D) Resident # 58 has multiple comorbidities affecting his nutritional status

F 325 states that “the resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible.”

The interpretive guidelines under guidance to surveyors states “the intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters of nutritional status” and “Acceptable parameters of nutritional status is defined as factors that reflect that an individual’s nutritional status is adequate, relative to his/her overall condition and prognosis.”

The interpretive guidelines under guidance to surveyors states defines “Unavoidable as the resident did not maintain acceptable parameters of nutritional status even though the facility had evaluated the resident’s clinical condition and nutritional risk factors; defined and implemented interventions that are consistent with resident’s needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.”

Resident # 58 was admitted to the facility with a diagnosis including Alzheimer’s Disease Severe with behavioral issues/Other Cerebral Degenerations, Atrial Fibrillation, Diabetes Mellitus, Hypertension, Congestive Heart Failure, Depression, Anxiety, Reactive Confusion and Bullous Dermatoses/Pemphigoid.

Resident # 58 started on Depakote Sprinkles in July of 2009 with an increase in August of 2009, and an increase twice in September for Diagnosis of Reactive Confusion secondary to Alzheimer’s Disease Severe with behavioral issues. He was having increased behaviors such as agitation, resistance and combativeness which continue to worsen.

Resident # 58 then developed a rash on 10/30/2009 which would over the next several months worsen, he would develop blisters and was treated for cellulitis two times secondary to red swollen arms from his shoulder to his fingertips.

It was suggested that the rash developed after his last Depakote increase in September could have caused the rash and with the continued progression and itchiness an allergic skin reaction was probably due to the Valproic Acid. There was even a question of Steven Johnson Syndrome which would prove to be incorrect. He was treated two times with antibiotics for cellulitis during which his arms from shoulder to finger tips were red and edematous. Resident # 58 has been to see two dermatologists secondary to his worsening condition. He

F323 continued from page 8a

develops blisters sporadically throughout his entire body, raised red itchy areas with limited relief.

After his second dermatology consult he was diagnosed with Bullous Dermatosis/Pemphigoid which is a blistering disease found almost exclusively in the elderly; large, tense bullae filled with clear serum form on normal and urticarial skin. Lesions predominate in the flexural aspects of the limbs and abdomen. This condition is treated with corticosteroids and immunosuppressive agents, such as azathioprine or cyclophosphamide. However, resident # 58 has an extensive list of allergies and is unable to take any of the medications that would provide him any great relief from this diagnosis secondary to his allergy list.

On 01/08/2010 it was noted that resident # 58 was complaining of chills, his temperature was 99.1, had a FSBS of 181 and was to receive his last dose of Keflex for cellulitis. This resident did not have a diagnosis of diabetes at this time. MD was notified of elevated blood sugar and an order for sliding scale insulin was received. His continued elevated blood sugars led to his new diagnosis of Diabetes Mellitus.

On 01/12/2010 it was observed that resident # 58 had 3+ pitting edema in both lower extremities, with increased erythema in his right lower extremity with an increase in temperature. Resident # 58's Edema Measurement Flowsheet indicates on the 12th of January he had 3+ pitting edema, 1/19/10 resident would not allow measurements, edema continues but decreased, on 1/26/2010 again would not allow measurements, but noted slight edema in both feet ankles thus indicating the resident would have a weight loss secondary to loss of fluid from edema.

On 01/17/2010 resident # 58 consumed 2000cc of fluids within three hours, his family was in and gave him another 480cc of fluids and three ice creams totaling 270cc. MD was notified with concern regarding his increase in fluid intake and fluid overload secondary to having 3+ pitting edema in lower extremities and red swollen forearms with taught shiny skin. New order obtained for fluid restrictions with the concern of fluid overload/fluid retention.

Facility policy and procedure states the any weight change greater or less than 5 pounds within 30 days nursing will notify the dietician on her communication logs for her review upon her weekly on-site visits. The facility failed to re-weigh resident # 58 in the specified time frame; however, the dietician was notified and reviewed at her next visit within the week. Resident # 58 had and received recommendations secondary to his weight loss. During the time resident # 58 was due for a re-weigh he had multiple episodes of agitation with resistive, combative behavior and refused to get out of bed making

F323 continued from page 8b

the re-weigh difficult to obtain for safety purposes for him and for staff and to not increase his anxiety and/or agitation as he was distressed already from his skin condition.

Resident # 58 had medication changes in which he started Methotrexate 2.5mg with gradual increases over the next few weeks. Side effects of this medication are nausea, vomiting, anorexia and diarrhea. He also receives Ativan, Lasix, Celexa, Coumadin, Oxycodone which all have potential side effects of anorexia, nausea, vomiting and diarrhea. He was also receiving Depakote which was increased over time which is known to cause swelling of arms and legs.

Resident # 58 primary physician had been updated on this either via telephone or fax on the following dates 1/1/10, 1/8/10, 1/12/10, 1/13/10, 1/14/10, 1/15/10, 1/17/10, 1/22/10, 1/25/10, 1/28/10, 2/3/10, 2/4/10, 2/5/10; he was seen by his primary physician on 1/4/10, 1/6/10, 1/11/10, 1/26/10, 2/10/10 regarding his condition and was immediately notified of his weight loss. Resident # 58 is also seen routinely by our Psychiatric consultant for his continued behaviors, i.e. agitation, resistance, combativeness on 9/2/09, 9/30/09, and 11/5/09. He is also seen by the dietician on 12/28/09, 1/18/10, 2/3/10, 2/15/10 and 2/23/10 for his nutritional needs. He was also seen by two dermatologists, the first visit was on 12/10/09 and the second dermatologist was on 1/13/10.

The facility has demonstrated and proved:

(A) The facility was in substantial compliance with F 325 as the resident's clinical condition prohibited him from maintaining acceptable parameters of nutritional status;

(B) The finding contradicts the regulation that states "maintains acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that this is not possible;

(C) There was no actual harm caused to the resident

(D) Resident # 58 has multiple comorbidities affecting his nutritional status

The facility requests informal dispute resolution for Tag F 325; respectfully maintains that it was and is in substantial compliance with federal regulations in respect to F 325; respectfully denies and disputes the allegation that it was deficient in respect to F 325; respectfully denies and disputes that any action or inaction on the part of the facility in respect to F 325 caused any harm or potential for any harm to any facility residents; and requests that F 325 be deleted from the public record.

The facility respectfully requests that this finding, F 325, be removed from the record.

How will corrective action be accomplished for those residents found to have been affected by the deficient practice; 02/17/10

The resident's weight was taken on 2/17/10 and a nutritional assessment has been completed by the Registered Dietitian (RD). Per the recommendation of the RD the resident's weight day has been changed to correspond with the RD's scheduled day in the facility.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 02/22/10

All residents have the potential to be affected. All residents' weight logs will be reviewed for weights being completed and any resident with a change in nutritional status will be evaluated and reported to the resident's physician.

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; 03/26/10

Policy and procedure has been reviewed and revised. Re-weighs will be obtained within a twenty-four hour period and the primary care physician and/or dietician will be notified of verified weight loss. Interventions/further interventions will be initiated.

On or before March 26, 2010, licensed nursing staff will attend an in-service. The in-service will be conducted by the Director of Nursing or designee. The in-service will cover

- Review of the regulation
- Review of the statement of deficiency
- Review of the plan of correction
- Care plan development
- Goals including measurable goals-dates
- Revision and updating of care plans as needed

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? 03/22/10

Beginning 03/11/2010 the Director of Nursing (DON) or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance. The audits will be conducted weekly for a month and then monthly for one quarter and/or 100% compliance has been achieved. The DON or designee will report the results of the audits to the Quality Assurance committee who will determine the further monitoring.

A handwritten signature in cursive, possibly reading 'K. Coe', with the date '3/22/10' written below it.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/18/2010
NAME OF PROVIDER OR SUPPLIER VERNON GREEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 61 GREENWAY DRIVE VERNON, VT 05354		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	Continued From page 8 the dates 1/3 /10 through 1/17/10 showed that there were 17 meals that he/she had eaten 50% or less of their meals and 5 meals that had been refused outright. There was no evidence that the charge nurse had asked for a re-weigh of the resident after the initial weight loss was documented. When the RD (registered dietician) visited on 2/3/10, she noted the 'significant weight loss of more than 6% in 30 days' The RD noted that the resident agreed to nutritional supplements and 2Cal was ordered 2 times daily. This did not occur until 1 week after the weight loss was initially documented.	F 325			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility policy regarding Weight Assessment and Intervention stated that "any weight change greater than or less than 5 pounds within 30 days will be taken the next day for confirmation" and he/she confirmed that the facility failed to re-weigh the resident until 2/2/10. The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to adhere to accepted standards of safe food handling and sanitation	F 371	F 371 Sanitary Conditions The facility has and continues to ensure that food is procured from sources approved by or considered satisfactory by Federal, State, or local authorities; and stored, prepared, distributed and served under sanitary conditions. How will the corrective action be accomplished for residents found to have been affected by the deficient practice; The findings do not state any residents were found to have been affected by a deficient practice.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 9 practices on the initial day of survey. Findings include: 1. Per observation on 2/16/10 at 2:50 PM during the initial tour of the facility kitchen, a meat slicer stored in the Dry Storage room was noted to have dried food debris on the circular blade and at the base of the slicer. A clear plastic cover over the slicer was soiled and had dried brown spillage on it. Per record review and interview during the tour, the Hospitality Director confirmed the status of the soiled meat slicer and cover and acknowledged that the food slicer was not on the Kitchen Audit Sheet or (daily) Cleaning Schedule and that this was an oversight.	F 371	<u>F371 continued</u> How will the facility identify other residents having the potential to be affected by the same practice; All residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The food slicer has been added to the cleaning audit as of 2/16/10. The slicer, cover, and cart were thoroughly cleaned and sanitized on 2/16/10. Any employee using the food slicer will be trained by the Food Service Director or Shift Supervisor on how to properly take apart, clean and sanitize the slicer, cover and cart. How will the facility monitor its corrective actions to ensure that the deficient practice will not occur? The food slicer must be checked by the Food Service Director (FSD) or Shift Supervisor after each cleaning and before storage. The FSD will review and revise the cleaning audit every six months to insure all equipment and physical plant items are audited. The Director of Hospitality Services will monitor and assist the FSD in this task. The FSD will report the results of the audits to the Quality Assurance committee who will determine the further monitoring.	02/16/10 02/16/10 03/22/10	

POC [Signature] 2/16/10
[Signature]